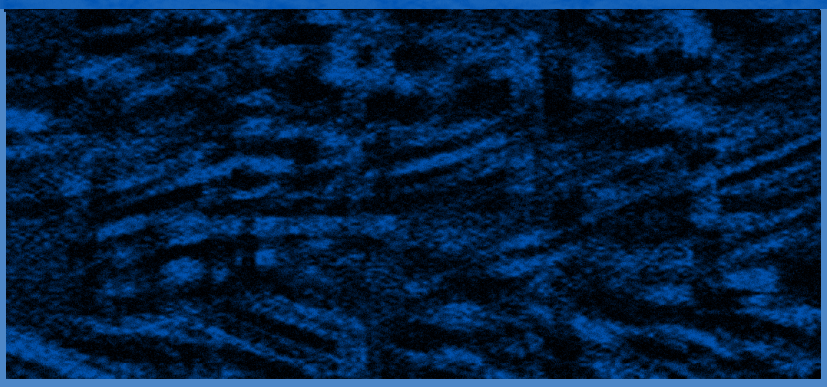
Section II

Family-Based Strategies



INCLUDED IN SECTION II

Family-Based Strategies

More and more children seem to be having trouble developing the skills they need to become competent, caring adults who can live together, peacefully and productively. The family is a major influence on children's development. Yet the family itself faces greater stresses; parents cannot always prevent or halt their children's early problems or substance abuse. This is true of families everywhere, not only—as stereotyped views sometimes hold—for young people who live in poverty, in communities of ethnic minorities, or with single parents. Families are asked to do more than ever, with less time and often with less support from cultural institutions—schools, clubs, churches, neighborhood groups—that in the past were a part of their lives on a regular basis. These institutions, too, need to be nurtured and cultivated.

In this guide we define the family as a constellation of adults and young people who share a social network, material and emotional resources, and sources of support. It may consist of one or two parents (or another caretaker) and a child or several children. It may be a group that is biologically related (such as two sisters and an aunt). It may be a group that lives

together through formal or informal assignment of guardianship (such as a household of adults who have come together). Parents may be married, never married, separated, divorced, foster, adoptive, or stepparents. Caretakers may be grandmothers or other extended family members; they may be friends regularly living in the household who are involved in the ongoing care of the children; occasionally they are older siblings.

We now know that substance abuse problems do not merely erupt in adolescence but emerge as a symptom of an ongoing pattern of development in the child. For prevention to be effective, it is necessary to move back "upstream." Practitioners need to examine the realities of life in particular families and see how changes in family patterns and behavior made two, three, even 10 years before the child reaches adolescence can alter the trajectory of events. Without time machines, there is no way to bring about changes in the early family life of the 14-year-old boy who today is involved in alcohol abuse. Practitioners, however, can apply some key lessons learned from research to the family life of the 8-year-old girl who lives next door. They can intervene in ways that may improve the outcomes for her and improve the likelihood that when she reaches the age of 14, she will not become involved in substance abuse. Influencing children and their families early may be the most productive option, but it is not the only one. Family interventions can change behaviors even in families with longer histories, more entrenched patterns, and older children.

That is what the research of substance abuse prevention offers family practitioners: evidence that suggests ways to influence family life and contribute to prevention. Not all efforts directed at parents are equally effective. In general, parent education or parent support programs are considerably less effective than highly structured approaches, such as behavioral parent training, family skills training, family therapy, or comprehensive family support programs.[29]

These family-based approaches do not directly address substance abuse among youth. Rather, they address known risk and protective factors that increase or decrease the likelihood that

children will begin—or continue—to abuse substances.[30] Research suggests specific ways that:

- providers can act to strengthen families (as one example, they can teach them improved communication skills)
- families can act to alter existing patterns of behavior in ways that enhance their children's abilities and skills (as one example, they can alter parental patterns of discipline)
- children, as they develop, can increase the protective factors that are likely to buffer them from risk of substance abuse when they become adolescents (as one example, they can develop improved social skills)

"We know how to intervene to reduce the rotten outcomes of adolescence and to help break the cycle that reaches into succeeding generations.Unshackled from the myth that nothing works, we can mobilize the political will to reduce the number of children hurt by cruel beginnings.By improving the prospects for the least of us, we can assume a more productive, just,and civil nation for all of us."

— Lisbeth Schorr
Within Our Reach: Breaking the Cycle of Disadvantage[31]

THE SCIENCE BASE FOR FAMILY STRATEGIES

A common base of research underlies many current efforts in substance abuse prevention. CSAP has established the Prevention Enhancement Protocols System (commonly called the PEPS), which synthesizes research-derived knowledge on specific prevention topics. This process produced a document called *Preventing Substance Abuse Among Children and Adolescents: Family-Centered Approaches.* The PEPS evaluated numerous published research studies and analyzed specific programs described not in published research studies but in well-designed unpublished studies. The Office of Juvenile Justice and Delinquency Prevention also uses this research base, since the strategies for strengthening families can make children more resilient to delinquency and violence as well as to substance abuse.

The PEPS has classified claims of efficacy for prevention programs on the basis of five types of evidence or sources of evidence.

Type 1: The program has received **public recognition, awards, honors, or mentions.**

Type 2: The program has appeared in a **non-peer-reviewed professional publication or journal.**

Type 3: Experts have scrutinized **program source documents** and agreed that the program was implemented and evaluated with scientific (or methodological) rigor, or a paper describing program implementation has appeared in a **peer-reviewed journal.**

Type 4: Experts have agreed in reviews of **multiple studies (e.g.,meta-analyses)** that the program was implemented and evaluated with methodological rigor.

Type 5: The program was replicated in settings and with populations different from those in the original implementation, and articles with evidence of replication have appeared in **peer-reviewed journals.**

The PEPS did not give these five types equal weight, however. While the first two types may provide some interesting information, the PEPS adhered to the standard that only types 3, 4, and 5 define the procedures that result in "scientifically defensible" findings.[32]

Using these types of scientific review and some additional rules of evidence, the PEPS arrived at four major strategies for family-based interventions that are supported by research:

- **Parent and family skills training** for general populations *(universal)* or for groups at risk *(selective)*
- **Parent and family skills training** for families whose children are exposed to multiple risks or to one very serious risk and who show evidence of behavior disorders or conduct problems *(indicated)*
- **Family in-home support** *(indicated)*
- **Family therapy** *(indicated)*

The four PEPS strategies share some characteristics in common:

- They focus on prevention; programs based on these strategies do not directly address existing substance abuse among children or adolescents.[33]
- They focus on the dynamics of the family as a whole, not on one particular individual in the family.

- They are based in theory that identifies the ways in which risks and protective factors interact to shape children's lives.
- They emphasize the importance of reducing risk factors *while also* increasing protective factors.
- They do *not* include parent education characterized by didactic, knowledge-only approaches.

This guide presents a fifth strategy that reflects the growing interest in the possibilities suggested by an early start in prevention. Research demonstrates the effectiveness of particular efforts that focus on **prenatal and early childhood home visits.**[34] Unlike the other four strategies, Strategy 5 focuses on behavior change in one family member—the mother. It seeks to improve her health (before and after her baby is born) and her ability to give the infant proper care in a safe environment. It seeks to keep the mother's life on track by supporting her in avoiding substance abuse and criminal behavior; practicing birth control and planning future pregnancies; reaching her educational goals; and finding adequate employment.

Details of the five family strategies follow.

Strategy 1

Parent and Family Skills Training for General Populations *(Universal)* and for Groups at Risk *(Selective)*[35]

Strategy 1 encompasses two kinds of skills training:

- **Parent training** is delivered to parents or other caretaking adults; it teaches them how to enhance protective factors and reduce risk factors tied to substance abuse.
- **Family training** is delivered to parents, other family adults, and/or children, either in sessions held separately or in sessions that bring together all family members for structured activities; it is designed to change the ways in which family members interact.

The structure of a family (its race and income, how often the family moves, educational level, and employment of parents), how a family functions, and the values it lives by all have an impact on children's capacity to develop prosocial skills and cope with life's challenges. Overall goals of programs using Strategy 1 include:

- promotion of physically and emotionally healthy children within the family setting

- improvement of relationships between parents and children
- increased capacity of parents to address specific problem behaviors of their children
- general improvements in the structure, functioning, and interaction of families

What This Has to Do with Substance Abuse Prevention

Strategy 1 skill-building sessions can enable families to better nurture and protect their children, assist the children in developing prosocial behaviors, and train families to deal more effectively with situations and problems that arise in the household.

If a program can (1) decrease behavior problems, such as conduct problems and antisocial behavior, in children and youth and (2) improve family functioning, it reduces the likelihood that youth will begin to abuse substances. In practical terms it may be some years before anyone can know if the children grow into youth that do or do not become involved in substance abuse. Nevertheless, research findings support the value of conducting effective parent and family skills training. If you use Strategy 1, you can have some confidence that the outcomes will be positive in the short term; these short-term outcomes themselves may improve long-term outcomes for the children.

Audience

Strategy 1 targets families not known to have any specific risk factors *(universal)* as well as families with children at risk who are exposed to specific risk factors *(selective)*. To review the relevant risk factors, see the exhibit in Section I, on page 14.

Objectives

Objectives define the changes that a program seeks to bring about. Programs based on Strategy 1 focus on a number of changes in parents, children, and families.

Objectives for *parents* include acquiring or improving parenting skills, child management abilities, psychological helping skills, relationship development, and empathy. Specific behavior changes that might be targeted to achieve these broad objectives include:

- improving communication, problem solving, anger management, and coping skills
- improving parents' own communication and relationship
- learning more appropriate ways to deal with children's behavior problems
- learning to use leadership skills that are less likely than forced authority to induce rebellion in the children
- reducing punitive and authoritarian sanctions and providing more consistent discipline

Objectives for *children* include improving general behavior, psychological adjustments, attachment to family, and commitment to school. Specifically, programs based on Strategy 1 may seek to help youth:

- improve their ability to listen and problem solve
- improve their ability to take responsibility for their own actions
- learn prosocial skills, such as coping with loneliness, making choices, controlling anger, recognizing feelings, and coping with peer pressure

Objectives for the *family* focus on improving family cohesion, organization, relationships, and conflict resolution. The specific changes targeted might include:

- reducing family stress levels and family conflict
- moving from hierarchical to more democratic decision making in the family
- increasing the amount of time family members spend together, with positive interactions

Activities

Programs in this category are usually delivered through structured activities, provided in community or clinic settings. Skill training sessions may be for (1) parents alone, (2) parents together with their children, and (3) parents and their children, trained separately. They include activities such as:

- didactic group sessions
- cognitive-behavioral workshops
- video presentations
- curriculum- and video-based training and modeling sessions
- lectures
- demonstrations
- role playing and skill practice sessions
- homework assignments, homework review
- supervised practice exercises
- games

NOTE:
Strategy 1 programs designed for a selective *audience may be longer or more intensive than those designed for a* universal *audience; may target a smaller number of participants (who are often specifically recruited into the program); and require more skilled staff, since they target multiproblem youth and families.*

Lessons Learned

Besides Strengthening Families (page 31), numerous other parent and family skills training efforts have been studied. Research *across* these programs yields the following lessons.[36]

- Parent and family skills training has positive effects on measures related to parents, the family, and children. Positive outcomes can include increases in parenting skills, problem-solving skills, child management skills, and coping skills, as well as improvements in attitudes.
- Parent and family training can improve parent-child family relations, increase family cohesion, and decrease family problem behaviors, family conflict, and substance abuse.
- Positive outcomes for children include increases in prosocial behavior and decreases in hyperactivity, social withdrawal, aggression, and delinquency.
- When parents' effectiveness improves through family skills training, parental substance abuse sometimes decreases.
- When parents who are being treated for substance abuse problems also take part in family skills training, the training sometimes has an impact on substance abuse above and beyond the treatment effect; participation may reduce the likelihood of relapse, especially among women.
- Videotaped training and education components can be effective and cost-efficient elements of parent training programs; added to therapist consultation and group discussion, they can promote parental modeling and improve parenting skills.

Strategy 1 Program Illustration:

The Strengthening Families Program (SFP)[37]

The Strengthening Families Program (SFP) is a family skills-training intervention *(selective)* targeted at 6- to 10-year old children considered to be at risk for substance abuse. The program was initially developed in Utah for children deemed to be at risk whose parents abused alcohol or other drugs. It has since been tested in a variety of settings, as well as for children who already demonstrate behavioral risk factors for substance abuse.

Goals

Strengthening Families is designed to reduce children's risk factors for substance abuse and other problem behaviors and to increase their protective factors.

Activities

SFP participants meet for two to three hours weekly for 14 weeks, in groups ranging in size from 5 to 14 families. There are three components to the weekly meetings. Parents and children attend their own sessions separately during the first hour—that is, a parent training session for the parents and a children's training session for the children. These are followed by a one-hour family training session, which children and parents attend together. Developers found that the time spent working together as a family made a major difference in helping the families make real and sustained changes in their family interactions.

Parent Skills Training includes lectures, demonstrations, discussions, role-playing, peer group support, games, and videos. Homework is also assigned. Each session focuses on a different topic and may consist of a variety of methods of instruction, depending on the subject as well as the strengths of the trainers and the preferences of the participants. Topics covered include "Developmental Expectancies and

Stress Management," "Communication," "Alcohol, Drugs, and Families," and "Limit Setting."

These lessons aim to increase parenting skills by increasing parents' attention, praise, and empathy for their children; increasing parents' use of effective discipline and decreasing their use of physical punishment; and decreasing parents' use of substances.

Children's Skills Training includes games, coloring and workbook activities, role-playing, puppet shows, and discussions; homework is also assigned. Children who follow group rules, which are explained at the start of the program, may receive small rewards for good behavior. Like the Parent Skills training, each session covers a different topic, including "Social Skills," "How to Say No to Stay Out of Trouble," "Communication I: Speaking and Listening," and "Coping Skills III: Coping with Anger." The curriculum is designed to increase children's skills by improving their ability to resist peer pressure to engage in various negative behaviors, including substance abuse, and increasing their knowledge about alcohol and other drugs; developing their self-esteem, recognition of feelings, and communication skills; reducing aggressiveness and other problem behaviors; and increasing compliance with parental requests.

Family Skills Training offers a forum for parents and children to practice their new skills. The curriculum is divided into three phases. In the "The Child's Game," parents learn how to listen to and understand their children, and how to gain insight into the behaviors and emotions of their children. "The Communications Game" offers instruction to parents on appropriate parenting behavior. In "The Parents' Game," parents learn to start introducing rules and restrictions to their children, using their new understanding of and empathy for their children.

The aim of these sessions is to improve family relationships by decreasing family conflict, improving family communications, increasing parent-child time together, and increasing planning and organization skills.

Sessions are held in facilities that are easy for participants to reach, such as family support centers in urban housing projects, community centers, local churches, and schools. The children's and family components of the program require comfortable space, with room on the floor or at small tables where the children can sit, age-appropriate toys, and blankets or rugs for families to play on together.

To increase participation and retention in SFP, sites have implemented various methods of assistance and incentives for participation. For example, besides the facilities being easy for participants to reach, some sites also provide transportation to the facilities. Meals, snacks, or recreational activities can be offered after the two-hour session itself. Besides acting as a reward, these activities give families additional time together to practice their new skills. Child care and adolescent activities may be offered for children not participating in the program.

Session leaders are recruited from local social service agencies and have counseling or social work experience. Three to six days of training (one to two days per program component), plus on-site practice and follow-up supervision, is suggested.

Implementation

Additional general guidelines for implementing family-based programs appear in Section III.

Evaluation

The Strengthening Families Program has been successfully modified to reflect cultural differences for African American, Asian/Pacific Islander, and Hispanic families as well as for a group of families in the rural Midwest. Independent evaluations of these programs have demonstrated positive outcomes, including:

- improved parenting skills, including decreased use of corporal punishment, less parental depression and social isolation, and decreased parental substance abuse

- improvement in child risk patterns, including reduction in children's problem behaviors, improved emotional status, increased prosocial behavior, and reduced reported intention to use tobacco and alcohol
- improved family function and environment, including family relationships, organization, and cohesion, and reduced family conflict

Contact

Dr. Connie Tait
Department of Health Promotion and Education
300 South 1850 East Room 215
University of Utah
Salt Lake City, UT 84112
Tel. (801) 581-7718

Strategy 2

Parent and Family Skills Training for Individuals at High Risk *(Indicated)*[38]

Strategy 2 is similar to Strategy 1; the primary difference is the audience.

What This Has to Do with Substance Abuse Prevention

Underlying parent and family skills training as an *indicated* prevention is the concept that decreasing children's and families' antisocial and other problem behaviors, fostering prosocial skills in children, and improving the family environment can reduce risk factors associated with substance abuse and can enhance protective factors.

Audience

Strategy 2 targets families whose children are exposed to multiple risk factors or who have a high level of exposure to a single risk factor. The children show evidence of behavior disorders or conduct problems.

Objectives

Objectives for programs based on Strategy 2 are similar to objectives for Strategy 1, with some additions.

Objectives for *parents* include acquiring or improving parenting skills, child-management abilities, problem-solving skills, communication skills, and crisis-management abilities, and improving parents' attitudes toward their children. Many of the behavior changes targeted in Strategy 2 are identical to those in Strategy 1. However, because the audience for Strategy 2 consists of families at high risk and children who have demonstrated possible behavior disorders or conduct problems, additional changes may be targeted, including:

- reducing parental depression
- reducing parental isolation (by strengthening social support, increasing interactions with people outside the home)
- supporting treatment participation for parents involved with substance abuse
- modifying mother's overinvolved or enmeshed behavior with children, often sons

Objectives for *children* include improving general behavior, acquiring or improving self-control and compliance, reducing antisocial and other problem behaviors, and reducing arrest rates. In addition to the specific behavior changes described in Strategy 1, programs based on Strategy 2 may aim to:

- modify oppositional-defiant or conduct-disordered behavior in children

Objectives for the *family*, too, draw largely from Strategy 1, including improving family cohesion, organization, relationships, and conflict resolution. The targeted behaviors are the same as in Strategy 1. The primary difference, again, is the audience; achieving similar behavior changes with families at high risk may require more concentrated activities, such as therapeutic counseling.

Activities

Activities are more likely to be carried out in therapeutic or clinical settings than is the case with Strategy 1. Activities include those used in Strategy 1, with the addition of therapy (noted in italics):

- didactic and group sessions
- cognitive-behavioral workshops
- video presentations
- curriculum- and video-based training and modeling sessions
- lectures
- demonstrations
- role playing and skill practice sessions
- homework assignments, homework review

- supervised practice exercises
- games
- *therapy*

Lessons Learned

Research across parent and family skills training programs *(indicated)* results in the same lessons as research across *universal* and *selective* parent and family skills training programs.[39]

Strategy 2 Program Illustration:

Helping the Noncompliant Child[40]

This family skills training program *(indicated)* targets parents whose children are ages 3 to 8 and are demonstrating noncompliant or other problem behavior that seems severe enough to warrant attention or referral; the program targets the children as well. In one program implementation, the group was made up of 20 mother-child pairs, with children representing different ages and genders and parents representing different occupations and marital and socioeconomic status.

Goals

The long-term goals of Helping the Noncompliant Child are to reduce serious conduct problems in preschool and early elementary school-aged children and to prevent future juvenile delinquency. Specifically, the program seeks to change a coercive style that parents may be using in their interactions with their children; establish positive, prosocial interaction patterns; improve parenting skills; and increase the children's prosocial behaviors and decrease their noncompliant behavior.

Activities

Helping the Noncompliant Child sessions take place weekly for an average of 10 weeks. Each session lasts 60 to 90 minutes. As a rule, the program is conducted

with individual families rather than with families who meet as a group. The meeting room is comfortable with several chairs and some toys that are age- and gender-appropriate for the children in the family. Session leaders (usually therapists or graduate students in clinical psychology) teach parenting skills through extensive demonstration and modeling. Parents take part in role-plays, then practice the skills they are learning with their children while the therapist gives some feedback. Then parents continue to practice the skills on their own at home.

The program consists of two phases. In Phase 1, parents learn to pay closer attention to appropriate behavior from their children, or, as it's described, "catch your child being good." Instead of paying attention to children only when they are behaving badly, parents learn to recognize and reward appropriate behavior through positive reinforcement: giving the child positive attention, for instance, or giving little rewards. They learn to limit their own negative interactions; to refrain from issuing additional commands or making pointed criticisms; and to ignore children's minor inappropriate behavior, such as whining and tantrums. By first watching session leaders behave in more effective ways, parents begin to see alternatives to their own usual patterns; and by practicing these new behaviors, they make them their own and familiarize their children with them.

In Phase 2, parents learn to give effective, concise commands to their children, one command at a time, and make the effort to give the child sufficient time to comply. When the children comply with their command, they learn to reward them with positive parental attention. If the child does not respond appropriately, parents are taught to use time-outs, which involve placing the child in a time-out chair for three minutes. After the time-out, the child is always returned to the original situation and the command is repeated.

Implementation

General guidelines for implementing family-based programs appear in Section III.

Evaluation

Helping the Noncompliant Child has been evaluated for both short- and long-term effects, and has shown positive outcomes:

- Parents continued to use the skills they acquired (such as giving effective commands, one at a time) consistently throughout the 4.5-year follow-up period.
- Children made improvements in their behavior and maintained them consistently throughout the 4.5-year follow-up period.
- Adolescents who had participated in parent training sessions when they were children demonstrated behavior that was generally consistent with a comparison sample of (nonclinical) young adults from the community.

Contact

Robert J. McMahon, Ph.D.
University of Washington
Department of Psychology, Box 351525
Seattle, WA 98195-1525
Tel. (206) 543-5136
Fax (206) 685-3157
mcmahon@u.washington.edu

Strategy 3

Family In-Home Support *(Indicated)*[41]

Strategy 3 provides crisis intervention. It addresses immediate needs, such as food, clothing, and shelter. To help solve the problems that caused the crisis, it includes long-range planning through advocacy, counseling, and referral. Intensive, multipurpose services are delivered in the home and usually involve all family members.

The overall goals of Strategy 3 include:

- decreasing the likelihood of domestic violence, child abuse, or neglect
- decreasing the likelihood that children will be placed in foster homes or institutions for juvenile delinquents

While in-home support can provide additional resources and encouragement that may help keep the family together, research underscores the fact that intensive family support services should not be required in every situation in which a child is recommended for out-of-home placement. Although these services are an important part of the range of family services within a community, they may not address the underlying family dysfunction or improve the child's well being, and may sometimes keep children in dangerous environments.[42]

What This Has to Do with Substance Abuse

Underlying in-home support as an *indicated* prevention is the concept that stabilizing the family environment is essential if parents are to nurture and protect their children more effectively. As seen with Strategies 1 and 2, improving the family environment can reduce children's risk factors and enhance protective factors.

Audience

Strategy 3 targets families whose children are exposed to multiple risk factors or who have a high level of exposure to a single risk factor. The children show evidence of behavior disorders or conduct problems.

Objectives

Objectives for *parents* include acquiring or improving parenting skills related to discipline, family relations, communication, and anger management

and decreasing the likelihood of engaging in child abuse and neglect. To achieve these objectives, counselors work with parents and children to help them:

- increase mutual positive reinforcement
- decrease maladaptive interaction patterns
- improve family dynamics in families with juvenile offenders or adolescents with strong antisocial behaviors
- improve communication and self-management skills
- learn effective discipline methods (parents)

Objectives for *children* focus on improving communication skills and anger management, increasing compliance with curfew and school attendance, and lowering rates of arrests and criminal activities among juvenile offenders. Programs following Strategy 3 may aim specifically to:

- reduce behavioral and emotional problems
- improve the functioning of juvenile offenders
- prevent the initiation of substance abuse

The primary objectives for the *family* are to prevent children from being removed from the family and to reunite families that have been split.

Activities

Activities are likely to be carried out in the home; referrals are made to other services outside the home as well. Activities may be provided for several months or up to a year and include the provision of:

- transportation
- cash assistance
- clothing
- food
- help with home repairs
- individual and family counseling
- crisis intervention
- behavior management training
- reunification services
- case management services
- referral to substance abuse treatment

Lessons Learned

Beside MST (page 41), other in-home support efforts have been conducted. Research across these programs yields the following lessons:[43]

- Although these programs represent a currently popular prevention approach, the body of relevant research is relatively meager, partly because of the ethical issue of assigning high-need families to nontreatment control groups.
- The complexity of family problems makes it difficult to design research that teases out the differing effects of the services provided.
- Nevertheless, there is some evidence that in-home support activities are effective in achieving their objectives.

Strategy 3 Program Illustration:

Multisystemic Therapy Program (MST)

This in-home support program *(indicated)* targets chronic, violent, or substance-abusing juvenile offenders ages 12 to 17 who are at high risk of incarceration or out-of-home placement; it targets their families as well. Most of the families have been mandated by the court to take part in the program as an alternative to having the children placed out of the home.

The program is based on the social ecological theory of behavior, which holds that individuals are influenced by interconnected systems, such as family, peer, school, neighborhood, and society. Behavior problems can stem from any one of these systems, from a combination of several systems, or from an interaction between two or more systems. Highly individualized for each family, MST is designed to address specific risk factors in any of these systems as necessary. It seeks to empower parents and families to improve family functioning, thereby enhancing protective factors in the child's natural environment.

Goals

The primary goals are to reduce youth criminal activity and other types of antisocial behavior (such as drug abuse) and, in the process, achieve long-term cost savings by decreasing incarceration rates and out-of-home placements for youth at high risk.

Based on assessments of the needs of individual families, MST aims to achieve one or more of these goals:

- improve discipline practices of parents or other caregivers
- improve family interactions
- decrease youth association with deviant peers
- increase youth association with prosocial peers
- improve youth school performance

- engage youth in prosocial recreational activities
- develop an extended support network for the primary caregiver, including extended family, neighbors, and friends, to help achieve and maintain positive changes

Activities

Within a week to 10 days of referral to the program, the therapist assigned to the family conducts a detailed assessment of family, peer, school, and social support systems in order to determine the relations between these systems, and the behavior problems identified in the young person. Interviewing family members and others connected with the youth and family, such as teachers, friends, and neighbors, the therapist assembles a collection of independent views. Assessment focuses on both the problems and the strengths of the youth and family. The therapist then works with the family to determine which problem areas to target over the course of treatment, highlighting existing strengths that can be used to bring about change.

Specific strengths and weaknesses of target families can vary widely. Nevertheless, assessments frequently identify common problems among many juvenile offenders and their families. Families often experience high rates of conflict and low levels of affection. Parents or other caretakers often disagree about discipline strategies; and personal problems (such as substance abuse) often interfere with their parenting abilities. MST seeks to teach caretakers the skills needed to improve the child's situation: for instance, communication and problem-solving skills; strategies for monitoring children; effective discipline and reward systems; and skills they can use to develop a better social-support network in the extended family and the community.

Frequently, juvenile offenders are involved with other delinquents or peers who use alcohol and other drugs. MST therapists train parents in intervention strategies: how to support and encourage their children's association with prosocial peers by, for instance, providing transportation or increasing privileges and how to impose sanctions when youth do associate with delinquent peers.

Where school performance is a problem, therapists teach parents to improve the family's interactions with school by communicating more effectively with teachers, structuring their children's time to encourage academic efforts, and giving positive rewards for improvements.

Because MST is so individualized, there is no specific duration or frequency of treatment: this is determined by family need. Sessions can often take place daily early in the treatment process or when progress has stalled. Midway through treatment, the therapist may visit two or three times a week and call several more times. Toward the end of treatment, sessions may dwindle to once a week. Visits may range from 15 to 75 minutes. In total, a typical treatment term is approximately 60 hours of contact over four months.

Implementation

General guidelines for implementing family-based programs appear in Section III.

Evaluation

Several studies have evaluated the use of Multisystemic Therapy with juvenile offenders and have consistently demonstrated similar results, including:

- 25 to 70 percent reductions in long-term rearrest rates
- 47 to 64 percent reductions in out-of-home placements
- significant improvements in family functioning, including family cohesion
- decrease in youth aggression in peer relations
- decrease in mental health problems for youth

Contact

Scott W. Henggeler, Ph.D., Director
Department of Psychiatry and Behavioral Sciences
Family Services Research Center
Medical University of South Carolina
67 President Street, Suite CPP
Charleston, SC 29425 Box 250861
Tel. (843) 876-1800
Fax (843) 792-7813
henggesw@musc.edu

Strategy 4

Family Therapy *(Indicated)*[45]

Strategy 4 helps family members improve the way they relate and talk to one another, the way they manage family life, and the way they solve problems. Family therapy helps the members develop interpersonal skills to improve communication and perceptions of one another; change behavior that no longer serves a useful purpose in the family group; decrease negative behavior; and create skills for health family interaction. The overall goal is to improve family dynamics.

What This Has to Do with Substance Abuse

Underlying family therapy as an *indicated* prevention is the concept that restructuring patterns of behavior (especially communication patterns), changing perceptions of family members, and improving their roles and functions will improve family dynamics and enable parents to nurture and protect their children more effectively. As Strategies 1, 2, and 3 demonstrate, improving the family environment can reduce children's risk factors and enhance protective factors.

NOTE: therapy, in Strategy 4, is used as a tool of prevention, distinct from thera-

py that is used as treatment in substance abuse treatment programs.

Audience

Strategy 4 targets families whose children are exposed to multiple risk factors or who have a high level of exposure to a single risk factor. The children show evidence of conduct problems or have diagnosed behavioral or emotional problems that increase their risk of developing substance abuse problems.

Objectives

Goals and activities are tailored to meet the needs of individual families; thus, the specifics can vary widely, even within the same program. However, broadly speaking, some objectives can be identified for programs based on Strategy 4.

Objectives for *children* focus on reducing behavioral and emotional problems, lowering recidivism rates, improving the functioning of juvenile offenders, and preventing the initiation of substance abuse.

Objectives for *families* include increasing mutual positive reinforcement and decreasing maladaptive interaction patterns; improving family dynamics in families with juvenile offenders or adolescents with strong antisocial behaviors; acquiring skills; improving communication; learning effective discipline methods; and learning self-management skills.

Activities

Family therapy usually involves sessions with a trained therapist who meets with family members as a group.

Lessons Learned

- Family therapy can be effective in improving family functioning, increasing parenting skills, and decreasing recidivism.
- Family therapy can be embedded within multi-component prevention efforts (such as in-home family support or school-based problem-solving counseling).
- Most of the research on Strategy 4 has focused on families of adolescents, not younger children. Family therapy that requires a participant's understanding of complex and interpersonal dynamics may not be appropriate for very young children.

Strategy 4 Program Illustration:

Structural Family Therapy (SFT) Program for Hispanic Families[46]

This family therapy program *(indicated)* was initially designed for Cuban American families with youth who demonstrate behavior problems and/or alcohol or other drug use. It has since been adapted for use with other Hispanic American groups as well as African American families.

SFT is based on the theory that the family is a critical source of risk and protective factors for youth behavior. Children from troubled families are at high risk for behavior and substance abuse problems. Positive family relations, on the other hand, can protect against other adverse conditions in a child's life.

SFT also addresses the potential for intergenerational and intercultural conflict in Hispanic families. Youth in these families tend to become more culturally assimilated then their parents; stress within the family can then place them at higher risk for problem behavior as well as problematic family relations. It is critical for counselors to understand these risks and conflicts and to address them within the context of the family therapy. The success of the program among Hispanic families has led to new cultural modifications for use in other groups.

Goals

Structural Family Therapy seeks to reduce youth behavior problems by decreasing negative family interactions that encourage, maintain, or permit undesirable behaviors; it also seeks to improve family relationships and parental control of youth.

Activities

SFT is tailored to the needs of the individual families it serves. Counselors work with individual families to develop positive relationship skills. In most cases, treatment takes place weekly, over the course of 12 to 16 weeks. Sessions are 60 to 90 minutes long and may take place in the home or in accessible community facilities.

Therapists who are trained in SFT and who are familiar with the cultural perspectives of the families observe family interactions and work with family members to improve family relationships. There are three phases of the program: *Joining, Family Pattern Diagnosis or Tracking, and Restructuring.*

Joining: During this process the counselor establishes the future working relationship of the group. The counselor must first gain the respect of each member of the family, and must establish a leadership role. He then tries to discover what each member of the family hopes to achieve. For example, the parents may wish to establish clear and consistent rules for the children, while the children may want their parents to nag less. *Joining* is complete when every member of the family has agreed to work with the counselor toward stated goals.

Family Pattern Diagnosis or Tracking: The counselor encourages the family to interact in its ordinary fashion while she observes. Passive observation is critical during this stage; if family members attempt to involve the counselor in the family interactions, she will encourage them to address one another instead. This process enables the counselor to determine which family processes most contribute to the negative behavior and to decide which modifications are necessary.

Restructuring: The counselor works with the family to modify the interactions that contribute to the problem behavior or "symptoms." The counselor will again encourage the family to interact, but in this phase intervenes to encourage members to try something different.

There are four major restructuring techniques. *Working in the present* requires the family to interact during the session in the ways they would at home. Rather than talk about a problem, behavior, or event that already occurred, they should enact current situations and work through them. *Reframing* seeks to create a different perspective on an interaction. For example, if a parent was in the habit of yelling at the child for his participation in antisocial activities, the counselor might suggest that the parent is demonstrating true concern about the child's well being. Hearing this acknowledged,

the parent may find better ways to express concern; the child may feel less rejected or abused and more inclined to respond positively.

The counselor must be able to understand and work with *boundaries and alliances.* Often in maladaptive families, alliances can develop between various members. For example, a mother and son may support one another in all situations against the father; the youth may get away with unacceptable behavior because of the alliance with his mother against his father. The counselor works to shift these alliances in order to restore power to the parents and enable them to work together to control their child's behavior. Where unhealthy alliances occur, boundaries of acceptable behavior are less likely to be clearly demarcated, because they depend on who is interacting with whom. So, along with readjusting alliances, the counselor can help parents form acceptable boundaries for children's behavior, and then maintain them.

Finally, the counselor assigns *tasks* that family members carry out at home after practicing them during the session. For example, a session may find the family practicing making rules for the children's participation in household chores. At home, the parents may try out similar techniques to make rules for completing homework.

Counselors take cultural norms into account during all three phases. For example, respect is central to Hispanic family interactions and culture; a counselor must not only understand this, but be able to gain the respect of the family and encourage the members to respect one another before treatment can even begin. For SFT to be successful, counselors must understand the cultural norms and traditions of their clients and know how to work within them.

Implementation

General guidelines for implementing family-based programs appear in Section III.

Evaluation

Structural Family Therapy has been evaluated in a number of clinical studies. It has been found to be highly effective in improving family functioning, decreasing behavior problems among juveniles, and reducing recidivism among juvenile offenders. Program impact was generally maintained at a six-month follow-up.

Contact

Jose Szapocznik, Ph.D.
(Contact: Victoria B. Mitrani, Ph.D.)
University of Miami
Department of Psychiatry, Center for Family Studies
1425 NW 10th Avenue, Third Floor
Miami, FL 33136
Tel. (305) 243-4592
Fax (305) 243-5577
vmitrani@mednet.med.miami.edu

Strategy 5

Prenatal and Early Childhood Intervention *(Selective)*

Prevention that takes place later in the life of a child, or in families that have already incurred significant risk factors, requires interventions that may be increasingly intensive in degree and costly to implement. Research has begun to verify the hypothesis that money and effort spent *early in the life of a family at risk* may result in more effective prevention, yield more positive outcomes, and ultimately cost less. Early intervention reflects the truth of the old proverb "A stitch in time saves nine."

Behavior problems among young children are often an early marker for later antisocial behavior. Noncompliant and aggressive behavior, and the academic dysfunction and peer conflicts that it can lead to, put children at risk for substance abuse when they are older.

Some important findings about the effects of early intervention come from research on juvenile crime and delinquency; these findings have implications for substance abuse prevention as well. Studies find that while the more troubling risk behaviors may become evident after children reach adolescence, the most chronic and serious offenders often show signs of antisocial behavior as early as the preschool years. Preschool and childhood interventions have shown preventive effects. (NOTE: Strategy 5 was not identified in the PEPS series; however, according to the same criteria that the PEPS followed, research on Strategy 5 adhered to Type 3. Replications are currently under way, funded by OJJDP [Type 4]).

How parents behave, both before their infants are born and in the first years, can have far-reaching effects on children's development. Poor mother-child interaction at age one, a study found, is associated with behavior problems at age six.[47] High maternal criticism, a low degree of maternal warmth and praise, and rigid control were associated in another study with children who later showed destructive behavior, negative attention seeking, and restlessness.[48]

How parents discipline children sends strong messages. When parents are permissive about children's aggressive behavior toward peers and siblings and set no clear limits, young children can easily draw the conclusion that aggressive behavior is all right.[49] Physical punishment is a critical issue in early childhood: surveys show that children are spanked most often at ages three and four.[50] Often parents repeat their own childhood experiences, disciplining their children in the same ways that they were disciplined. Physical punishment sends the message that it is all right for some people to hit other people; it also suggests to children that at least some of the time, love and violence go together.

Early childhood is the time when the effects of the family are most evident and outside forces have only begun to directly influence the developing child. This is a time when children are still malleable, when aggressive tendencies may be amenable to change.[51] Even when both parents are involved in caring for the young child, mothers are commonly the primary caretaker; the research base for this strategy specifically focused on mothers.

To take advantage of this window of opportunity and help families establish positive patterns, one approach to prevention advocates intervening with young mothers in groups at risk even before the child is born. Strategy 5 encompasses **prenatal and early childhood home visits** that are designed to change the behavior of new mothers in ways that can strengthen the child's chances for healthy development from an early age.[52] The home visitors are usually registered nurses, lay therapists, or parents' aides. They receive considerable training, are well supervised, and make and maintain connections with individual parents over time.

Overall goals of programs using Strategy 5 include:

- improving the mother's health and habits so that she delivers a healthy baby
- improving the mother's ability to give the infant proper care in a safe environment
- keeping the mother's life on track by supporting her in avoiding substance abuse and criminal behavior; practicing birth control and planning future pregnancies; reaching her educational goals; and finding adequate employment

Strategy 5 programs do not focus only on mother-child interactions. They address the psychological needs of the mothers, especially their sense of mastery and competence. They also address the life situations and stresses that can interfere with parents' positive adaptation to pregnancy, birth, and the early care of their child.[53]

What This Has To Do With Substance Abuse Prevention

Early intervention programs that reduce antisocial behavior help protect children from substance abuse (as well as from delinquent and violent behavior). Three important risk factors associated with the early development of antisocial behavior *can* be modified: maternal behaviors during pregnancy that may affect children's neuro-psychological development; child abuse and neglect; and events that disturb the healthy life-course of the mother.

Audience

Strategy 5 targets low-income, first time mothers and, unlike the other strategies, is primarily concerned with mothers rather than with fathers or other caregivers. Because pregnancy is generally a time when women are more willing to decrease alcohol or drug use and sign up for parenting classes, programs often target pregnant women for recruitment and interventions.

Programs based on Strategy 5 are likely to focus on objectives such as the following:

Objectives for the mother

- Learn and apply healthy pregnancy practices that prevent low birth weight (improving diet, giving up cigarette smoking and the use of alcohol or other drugs)
- Learn to deal with depression, anger, impulsiveness, and substance abuse problems in order to reduce chances of child abuse and neglect
- Learn about normal child development
- Increase her ability to "read" her baby's signals and anticipate his or her needs
- Learn effective use of social systems and community resources through referrals
- Increase her confidence and the skills necessary to set and achieve goals she may want to attain, such as completing her education, finding work, and avoiding unplanned subsequent pregnancies

Activities

- home visits (prenatal) that help women improve their health and behaviors during pregnancy, prepare them for delivery, and encourage them to think ahead and consider family planning and school or employment-training options
- home visits (following the birth) to support the mother in her care of the infant and her to plans for school or work
- efforts that link the mother to health and social services

Strategy 5 Program Illustration[54]

Prenatal and Early Childhood Nurse Home Visitation

Prenatal and Early Childhood Nurse Home Visitation is an in-home support program *(selective)* that targets low-income women who are pregnant with their first child, particularly those who are teenaged and unmarried. Care continues through the first two years of the child's life.

Delinquent youth can begin to show signs of antisocial behavior as early as the preschool years; this behavior can be associated with several risk factors at the very beginning of life. Unhealthy practices by the mother during pregnancy (such as smoking or using alcohol or other drugs) can lead to preterm delivery, low birthweight, and neurodevelopmental impairment. Following birth, early child abuse and neglect, as well as difficulties in the mother's life-course, can have strong negative effects on a child's social development. Prenatal and Early Childhood Nurse Home Visitation seeks to reduce these three risk factors and improve the health and social functioning of mother and child by working with the family even before the child is born.

Goals

There are three overarching goals of Prenatal and Early Childhood Nurse Home Visitation, which can each be broken down into a series of objectives. The first is to improve the outcomes of pregnancy, specifically by reducing rates of preterm delivery, low birthweight, and obstetric complications. To achieve this goal, the program works with expectant mothers to reduce health risks such as substance use, improve dietary habits, and identify health problems early and navigate the health care system to receive treatment before they become more serious.

The second goal is to improve infant health and development by reducing child injuries, abuse, and neglect; enhancing infants' developmental accomplishments; and providing early attention to emerging behavioral problems. To this end, nurses

help parents develop effective parenting skills and create home environments that are safe and educationally enriching for their children.

Finally, the program seeks to improve the mother's own life-course development in order to reduce future unintended pregnancies; increase educational achievements and labor-force participation; and reduce welfare dependency. To do this, nurses help parents develop a vision for the future, reasonable expectations for their child and future children, and the confidence and skills necessary to participate in the work force. They also help parents learn to utilize the health and social services system, as well as other resources that may be available to them through their families or communities.

Activities

Prenatal and Early Childhood Nurse Home Visitation should begin as early in the pregnancy as possible. In previous trials, women have generally been recruited through providers of prenatal care, including private physicians and obstetric clinics. Women receive home visits, lasting about 60 to 90 minutes, from trained female nurses.

Because women enroll in the program at various stages of their pregnancies and with different knowledge, motivation, and learning capabilities, the activities in this stage vary considerably among families. However, activities can be divided into three types of objectives: promoting behavior change that affects maternal and child health and pregnancy; helping mothers develop supportive relationships with family and community; and linking the family with health and human services.

During the first four weeks of participation in the program, expectant mothers receive visits once a week; after that, they receive visits every other week until delivery. Nurses concentrate on encouraging women to adopt healthy behaviors and prepare for delivery. Specifically, nurses may:

- help women improve their diets; monitor weight gain; eliminate smoking and alcohol and other drug use; exercise regularly; and take sufficient rest

- teach parents to identify signs of pregnancy complications and use the health care system to address these problems before they become serious
- prepare parents for labor, delivery, and early care of the newborn
- encourage mothers to plan early for subsequent pregnancies and for contraception, returning to school, or finding employment

Following delivery, mothers receive visits weekly for six weeks, then every other week until the twenty-first month. For the last three months of the program, they receive visits monthly. During this time, behavioral objectives include:

- improving mothers' understanding of their child's temperament and emotional needs
- promoting physical care of the child, including arranging a safe home environment and appropriate child care
- helping mothers adapt to changing roles
- encouraging mothers to clarify their plans for school, work, and family planning and helping them to act on those plans (e.g., helping with job search, choosing appropriate contraception)

Throughout the program, nurses seek to enhance informal support for mother and child through family, friends, and the social service system. Nurses assess potential sources of support for the mother by asking her about friends, boyfriends, and other family members and by observing interactions. They then encourage women to make use of the resources available to them. In particular, the mother's "significant other" or her husband, whether or not he is the child's father, is seen as an important figure in the child's life. Nurses must be sensitive to situations where new ideas introduced to the family might create difficulties or hostilities among the family, and to situations where a woman might be in an abusive relationship.

Nurses seek to further aid families by connecting them with formal health and social services. They encourage mothers to keep prenatal and early childcare appointments and to stay in contact with doctors in case of health emergencies. With the mother's permission, nurses may send observations and reports to the family's doctors, both to help them provide informed and sensitive care and to help the mother interpret and follow doctors' recommendations. Where necessary, nurses aid parents in establishing contact with other social services such as public assistance, Medicaid, foodstamps, WIC, Planned Parenthood, counseling services, and educational services or job training.

Implementation

General guidelines for implementing family-based programs appear in Section III.

Evaluation

An evaluation of Prenatal and Early Childhood Nurse Home Visitation that took place in Elmira, New York, including a 15-year follow-up study, showed a range of positive outcomes in contrast to a comparison group, including:

- 25 percent reduction in cigarette smoking during pregnancy
- 75 percent reduction in preterm deliveries
- 79 percent fewer verified reports of child abuse or neglect
- 44 percent fewer maternal behavioral problems due to alcohol and drug abuse
- 56 percent fewer arrests among the 15-year-old children
- 56 percent fewer days of alcohol consumption by the 15-year-old children

When targeted at low-income women, the program is estimated to save government agencies more than its initial costs by the time the first child reaches age 4, primarily because of reduced future pregnancies and related use of government health and welfare programs. One report estimated that by the time children from families at

high risk reach age 15, the cost savings are four times the original expenditure as a result of reduced crime and reduced reliance on government health and welfare programs, as well as additional revenues from taxes paid by working parents.

Contact

Ruth A. O'Brien, Ph.D., R.N.
Kempe Prevention Research Center for Family and Child Health
1825 Marion Street
Denver, CO 80218
Tel. (303) 864-5210
Fax (303) 864-5236
obrien.ruth@tchden.org

NOTE: See also Other Resources in Appendix A, which contains a list of exemplary, model, and promising programs identified by the Strengthening America's Families Project at the University of Utah, Department of Health Promotion and Education, under a cooperative agreement awarded by the U.S. Office of Juvenile Justice and Delinquency Prevention.